Testimony of

VIETNAM VETERANS OF AMERICA

By

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Executive Director for Policy and Government Affairs

Before the

Subcommittee on Health,
Committee on Veterans' Affairs
United States House of Representatives

Concerning

Ten Bills on Health Care Issues for Veterans

April 26, 2007

Chairman Michaud, Ranking Member Miller, and members of the Subcommittee on Health, Vietnam Veterans of America (VVA) thanks you for the opportunity to testify here today. And on behalf of our officers, our Board of Directors, our members and their families, we thank you, too, for the important work you are doing, and the initiatives you are taking, on behalf of our nation's veterans.

We would like to focus our comments this morning on three of the bills up for your consideration. They are H.R. 463, H.R. 1944, and the discussion draft of the "Rural Veterans Health Care Act of 2007."

Priority 8 Veterans/H.R. 463, the "Honor Our Commitment to Veterans Act," would re-open the VA health care system to Priority 8 veterans. These are veterans with an income of less than $28,000 a year who are not afflicted with a service-connected disability and who agree to make a co-payment for their health care and prescription drugs.

Back in 1996, when Congress passed the Veterans Health Care Eligibility Reform Act, the VA was able to implement major cornerstones of its plan to reform how it provided health care. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health care system. This the VA has done, and in the process it has transformed a mediocre, inefficient system into a national model.

However, the law – that's Public Law 104-262 – gave the Secretary of Veterans Affairs the authority and responsibility to determine eligibility for enrollment based on available resources in any given fiscal year. Although the law did not mandate a level of funding or a standard of care, it did establish an annual enrollment process and categorized veterans into "priority groups" to manage enrollment.

On January 17, 2003, the Secretary made the decision to "temporarily" suspend Priority 8 veterans from enrolling. While this decision may be reconsidered on an annual basis, every budget proposal from the Administration since has omitted funding for unenrolled Priority 8 veterans and attempts to discourage use and enrollment of those "higher income" veterans.

Priority 8 veterans are, for the most part, working- and middle-class Americans without compensable disabilities incurred during their military service. In its budget proposal for fiscal year 2007, the VA estimated that some 1.1 million of these "higher income" veterans would be discouraged from using *their* health care system because of a $250 enrollment fee and increased co-pays for prescription drugs. Thankfully, you in Congress have not let this scheme get much beyond the proposal phase.

H.R. 463 would amend Section 1705 of title 38, United States Code, by adding this new subsection: *The Secretary shall administer the health care enrollment system under this section so as to enroll any veterans who is eligible under this section for such enrollment and who applies for such enrollment.*

Enacting this bill into the law of the land would keep the promise, keep the covenant with those veterans who, for whatever reasons, would choose to use the VA for their health care needs. We believe that their addition to the rolls would ease some of the fiscal pressures experienced by the VA insofar as it is Priority 7 and 8 veterans whose private health insurance accounts for some 40 percent of the VA's third-party collections.

Of course, the bottom line is funding – the funding Congress provides – to enable the VA to accommodate those Priority 8 veterans who want to avail themselves of the VA's medical services. VVA will be releasing shortly a White Paper on veterans' health care funding, which will place this issue in context.

TBI/Traumatic brain injury suffered by our troops in Afghanistan and Iraq has become so relatively common that it is referred to by its acronym, TBI. This affliction is not new; it has only been so codified because of the carnage caused by IEDs, improvised explosive devices, another acronym that has been incorporated into the dialect of war.

We understand that the Administration is going to order the military to screen all returning troops for mild to moderate cases of TBI; those whose brain injuries are more serious are quite obvious to clinicians. **H.R. 1944, the "Veterans Traumatic Brain Injury Treatment Act of 2007,"** would

go a long way toward assuring troops afflicted with this debilitating condition that help will be there for them. Focusing TBI care at four VA polytrauma centers, establishing and maintaining a registry of veterans diagnosed with TBI, and developing and inaugurating a comprehensive program for long-term TBI rehabilitation will go a long way towards healing the wounded from these latest military ventures.

Rural Veterans Access to Care /How to provide more convenient access to quality health care for veterans residing in rural areas has been the subject of more than a few hearings over the past two sessions of Congress. The language in this proposed bill is as sensible as it is needed. It would establish pilot projects to see what is most effective in providing care. One of these pilots would expand access to Vet Centers via mobile centers in rural areas. Another would establish a health information technology program.

Perhaps more importantly, this legislation would direct the Secretary of Veterans Affairs to establish an Advisory Committee on Rural Veterans, which would identify specific problems and areas of concern and suggest cost-effective solutions. It would require the Under Secretary for Health to designate a minimum of four VA health care facilities as the locations for centers of rural health research, education, and clinical activities. And it would establish programs to enhance the education, training, recruitment, and retention of nurses and other health professionals in rural areas.

In seeking ways to better serve our rural veterans, this bill would not impose bureaucratic "solutions" that could and, we believe, would only serve to undermine the VA health care system. **H.R. 92, the "Veterans Timely Access to Health Care Act,"** would give the VA a scant 30 days to set up an appointment with a primary-care provider; if a VA medical center is unable to meet this standard for access to care, the option would be to send a veterans to a non-VA facility. **H.R. 1426, the "Richard Helm Veterans' Access to Local Health Care Options and Resources Act,"** would offer an eligible veteran the option of obtaining health care from a non-VA facility or provider. **H.R. 1527, the "Rural Veterans Access to Care Act,"** would expand the use of fee-basis care through which private hospitals, health-care facilities, and other third-party health-care providers are reimbursed. It would impose a series of conditions, or distances, to help define "rural."

Like **H.R. 1527**, **H.R. 315**, the inelegantly named **"Help Establish Access to Local Timely Healthcare for Your Vets (HEALTHY Vets) Act of 2007"** would add bureaucratic clutter to those whose responsibility it is to provide health care for veterans in "geographically inaccessible" areas.

Rather than improve health care for veterans, this quartet of bills, along with **H.R. 339, the "Veterans Outpatient Care Access Act of 2007,"** would, if enacted, usurp the VA health care system. Today, one out of every ten VA health care dollars goes to clinicians and facilities outside the VA system. Through a scheme called Project HERO – the acronym for Healthcare Effectiveness through Resource Optimization -- the VA is attempting to get a better handle on the dollars spent by VA medical centers on care provided outside of the system. We believe that HERO – and this quartet of bills – would only serve to hurt what has developed into one of the best-managed care systems in the nation. HERO is a pilot in four VISNs, one that we believe will eventuate in half care for twice the cost.

One bill we do applaud is **H.R. 538, the "South Texas Veterans Access to Care Act of 2007."** "They've been looking at this for a long time," one VVA leader in Texas told us. "We did get an outpatient clinic in Conroe, in East Texas, but there are a lot of veterans in South Texas who are poorly served." If one in five of the 114,000 veterans there uses the VA as their health care provider, that's 11,400 who have to trek up to San Antonio for any real care.

H.R. 538 basically says, let's find out the facts, whether the needs of veterans in far south Texas for acute inpatient care would best be met through a project for a public-private venture to provide inpatient services and long-term care in an existing facility, through construction of a new full-service, 50-bed hospital with a 125-bed nursing home, or through a sharing agreement with a military treatment facility.

This is a very worthy bill, one that deserves serious consideration by this subcommittee and by the HVAC at large.

VVA also endorses **H.R. 542**, which would require the VA to provide mental health services in languages other than English, as needed, for veterans with limited English proficiency. While it can be argued that, to

make it in today's military a troop needs proficiency in English, it is quite possible that (s)he is more conversant, and more comfortable, speaking in his/her native language. And many families of our diverse population of service members are hardly fluent in English. When troops return from places like Iraq, which have seared their soul and messed up their mind, and need counseling, it is highly beneficial to have a trained and competent counselor or therapist who can "relate" better because (s)he speaks Spanish, or French, or Vietnamese.

Finally, two bills that would effectively expand chiropractic care in VA medical centers, **H.R. 1470 and H.R. 1471**, are also worthy of passage – if proper standards of care are spelled out and enforced. We also would encourage, as part of these bills, a mandate for the VA to examine other "alternative" forms of medicine, so long as they conform to VA's evidence-based medical study. To this end, VVA suggests that part of this legislation should direct the Secretary of Veterans Affairs to appoint a committee to look at the efficacy of these alternative medical techniques with an eye toward integrating the most worthy of them into the VA health care system.

This concludes our testimony. Again, VVA is appreciative of having been afforded the opportunity to testify on the merits of these bills. We would be pleased to respond to any of your questions.

VIETNAM VETERANS OF AMERICA
Funding Statement
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The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

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Richard F. "Rick" Weidman is Executive Director for Policy and Government Affairs on the National Staff of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam War, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo as statewide director of veterans' employment & training (State Veterans Programs Administrator) for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans (NCHV), and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities - Subcommittee on Disabled Veterans, Advisory Committee on Veterans' Entrepreneurship at the Small Business Administration, and numerous other advocacy posts. He currently serves as Chairman of the Task Force for Veterans' Entrepreneurship, which has become the principal collective voice for veteran and disabled veteran small-business owners.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veterans affairs. He attended Colgate University (B.A., 1967), and did graduate study at the University of Vermont.

He is married and has four children.